DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 22 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21707

Registration District No. 306 — Primary Registration District No. 5424 — Registrar's No. 10

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Gasconade

(b) City or town: Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 6 23

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis

(c) City or town Sedalia (If outside city or town limits write "RURAL")

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME A. S. WRIGHT Jr.

3. (b) If veteran, name war No.

3. (c) Social Security No. 491-07-4204

4. Sex Male

5. Color or race W

6. (a) ~~Single, widowed~~, married, divorced

6. (b) Name of husband or wife Sidney Tucker

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Jan. (Month) 6 (Day) 1890 (Year)

8. AGE: Years 49 | Months 5 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Hughesville, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Pet. Oil Co. Driver

11. Industry or business Oil Co

MOTHER FATHER

12. Name John Wright

13. Birthplace Indiana U.S. (City, town, or county) (State or foreign country)

14. Maiden name Adilade Beard

15. Birthplace Illinois U.S. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. S. Wright

(b) Address Sedalia, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-12-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo.

18. (a) Signature of funeral director Tappmeyer & Murray

(b) Address Owensville Mo R 277

19. (a) 6-10-1940 (Date received local registrar) (b) [signature] (Registrar's signature)

John Engelbrecht (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10 year 1940 hour 7 minute a. M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw him alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mobile	
Coll	
Due to Car accident Fractured Skull	1 hr.
Due to No other car involved. Verdict of Coroners	
Other conditions (Include pregnancy within 3 months of death) Jury	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence June 10-40

(c) Where did injury occur? Near Drake Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

(Specify type of place)

While at work? auto (e) Means of injury

23. Signature C. C. Dungan (M. D. or other) Coroner

Address Bland Mo Date signed 7-10-40

21D m
18

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
Chester W. Sassmann, Registered Apprentice No. 216,
working under my personal supervision.

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address Owensville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 21707

Registration District No. 306 Primary Registration District No. 2424 Registrar's No.

ROWENA MOORE

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Bascomade
(b) ~~City or town~~ Boeuf T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Albert S. Weigel
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased Jan (Month) 6 (Day) 1890 (Year)

8. AGE: Years	Months	Days	If less than one day
50 49	5	4	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 6-10-1940 (Date received by local registrar) (b) John Engelbrecht (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. A. Bunge (M. D. or other)
Address Date signed

SUPPLEMENTARY

S. No. 2B
—2-21-40
I X22659

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Registration District No. 306 Primary Registration District No. 2424 Registrar's No.

1. PLACE OF DEATH:
(a) County Dazeong Twp.
(b) City or town Bolen
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME A. S. Wright
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Automobile accident	
Due to Car accident	
Due to Fractured skull	
Due to No other Car involved	
Due to Coroners Verdict	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operation Non Collision
Of autopsy
6-10-40 C A Bunge PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature C A Bunge (M. D. or other)
Address Bland Mo Date signed

SUPPLEMENTARY